Authorization for Release of Information – Compound Release

Name of Patient____________________________ Date of Birth _________________________
Williams Family Dentistry is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	**Check type of information that can be given to person/entity on the left in the same section.**
○ Voice Mail	○ Medical/Treatment ○ Financial ○ Other_________________________
○ Other person (s) (please provide name and phone number)	○ Medical/Treatment ○ Financial ○ Other:
○ Email communication-Provide email address* *For email communications to occur, please accept the disclosure below:	○ Medical/Treatment ○ Financial ○ Other:
○ For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email as selected.	
○ Photo of patient received by patient or legal guardian ○ Photo taken by staff (Example: pre/post procedure) ○ Other	○ May be posted in office ○ May be posted on website ○ Other:

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____Date_______________________

Signature of Patient or Legal Guardian

*Description of Legal Guardian's Authority

Revised August 2015